SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: ADMINITRATIVE REQUIREMENTS
	Subject: Quality Assurance Process

DEFINITION

The Community Services Bureau of the Department conducts comprehensive evaluations of case management teams (CMTs) to meet the bureau's quality assurance requirements. Department staff will perform announced quality assurance reviews. The purpose of the review is to insure that optimal services are being provided to members and that program rules and policies are being followed. Quality assurance results are utilized to improve the programs and services.

The quality assurance review is divided into two parts. Part one is the provider prepared standards. This is a documentation process where the CMT provides information to demonstrate compliance with specific standards. This is done prior to the onsite review at the request of the Regional Program Officer (RPO). Part two is the onsite review of records.

Below are some helpful hints for review:

1. Make sure you know where all appropriate documentation is located.
2. Provide Department staff with private and ample workspace.
3. Review your own records (see CMT Chart Audits below).
4. Don't be afraid to ask questions.
5. Submit your provider prepared standards by the deadline requested by the RPO.
6. Understand review dates can be tentative and may be moved due to staff conflicts and/or bad roads.
7. This is a learning experience for all of us.

CMT CHART AUDITS

Case management teams are also required to conduct chart audits at least quarterly on a sample of cases. No less than a ten percent (10%) random sample should be conducted when caseloads are at or near maximum. The

sample size should be increased when caseloads are lower. The audit findings from case reviews are reported on the Report 1 of the quarterly reporting requirements (Refer to HCBS 899-2) or a CMT form that has been approved by the RPO.

QUALITY ASSURANCE REVIEW FREQUENCY

Each case management team must receive a full review at least once every three years and a minimal review each fiscal year between full reviews. The type of review conducted is determined by the RPO. The decision is based on the following:

1. The team's previous review; and

2. The team's performance since their last review.

PERFORMANCE REVIEW STANDARDS – FULL REVIEW

Performance standards consist of the standards outlined below:

1. Required documentation is readily available and principles of charting are followed. Refer to HCBS 804 and CSB 306. All member charts must contain the appropriate forms and be filled out completely, appropriately and correctly.
    a) Chart contains copies of the Level I (SLTC-145) and if applicable, the results of the Level II.
    b) Chart contains a copy of the Level of Care Determination (SLTC-86) and application.
    c) Chart contains a copy of the Screening Determination (SLTC-61).
    d) Chart contains an intake sheet. The admit date should equal the enrollment date and must be equal to or later than effective date on the SLTC-61 and equal to effective date on the DD/SLTC-55.

2. The Plan of Care (POC) is complete (refer to HCBS 809-1, 809-2, 809-3.) The date of referral and referral source should match those on the intake sheet (SLTC-136). The services and units on the cost sheet should match the services and units in POC service delivery plan and should match the services and units in the prior authorization sent to XEROX.

3. Plan of Care reevaluation occurs at least once every 180 days, refer to HCBS 899-15). The chart should contain all the necessary reevaluations and amendment forms. These should be filled out appropriately.

4. Progress notes are complete. (Review CSB 306.) Progress notes should reflect the CMT involvement in the member's life, the monitoring of quality of care and the review of the necessity of selected services. All entries must be signed and dated. Both team members must make reevaluation visits and at least one team member should have signed off on that entry.